PARTNERSHIP HEALTHPLAN of CALIFORNIA

PROVIDER INFORMATION CHANGE FORM

For PHC Use Only

PR Rep: _____

PHC # _____

☐PCP: ☐South ☐North

☐ Other: ☐South ☐North

☐ Non Visit Directory Validation

Instructions: Complete this form to make changes to the Provider Directory, change the pay to address, or update an individual provider.

Practice/Facility Name as Currently Listed in Provider Directory:	**County:**	**Billing NPI #**

City:	State:	Zip:

***Practice Information: Check all that apply and provide information requested**

☐ **Change Practice Name to:**

☐ **Change Service Location to:**	Street:	City:	State:	Zip:

☐ **Change Telephone # to:**	☐ **Change Fax # to:**

***Change of Office Hours: please list the hours for <u>each day of the week</u> you are open, not just the day you are changing. e.g., 8am -5pm**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Change of Taxpayer Identification Number (TIN) or National Provider Identifier (NPI)

☐ **Change TIN from:**	Old#	**to:**	New #	*** A new W-9 Must be attached for change to be processed**
☐ **Change NPI from:**	Old#	**to:**	New #	*** Proof of Medi-Cal Must be attached for change to be processed**

Change Pay to Address: Changes that directly impact the issuance of your 1099 requires the submission of a NEW W-9 with this form

New Pay To Address	Street:	Suite #:

City:	State:	Zip:

Phone:	Fax:	Effective Date:

*** Change to Member Assignment (select one) For PCPs Only**

☐ **Accepting New Patients:** New PHC members and members who are selecting a new provider can select your practice without restrictions ☐ 0 – 18 years ☐ 19 years and over ☐ 0 – 99 years

☐ **Accepting New Patients With Auto-Assignments:** PHC members who have not selected a Primary Care Physician (PCP) will be assigned automatically to an open practice that is accepting auto-assignments based on zip code.

☐ **Accepting Existing Patients**: PHC members who have an existing or past relationship with your office can request to be assigned to your practice. Members who lose and then regain eligibility are automatically re-linked to their last PCP. For any exception, PHC must receive verbal or written approval from your office prior to assigning the patient to your practice.

☐ **Not Accepting New Patients:** Practice closed to all **new** PHC members.

Turn This Form Over – Update Is Not Valid Without Authorized Signature

To add a NEW provider or a NEW location to an existing group, please contact Credentialing at credentialing@partnershiphp.org to initiate the process or inquire about the status.

Change Information for an Individual Provider within your organization:

Name of Provider:

Change in Employment Status or Location within your organization: (check one)

☐ **Retired** – Effective Date:	☐ **Termed Employment/Resigned** – Effective Date:

☐ **Moved or Added Additional Site(s)** – Effective Date:

Check the Appropriate Box below for Moving an individual Provider and Complete ALL Applicable Information.

☐ The Provider has moved from one site to another within your organization

Remove Provider from Directory Listing at this location: _____

Add Provider to Directory Listing(s) at this location: _____

☐ The Provider added additional location(s) within your organization

List *all* locations within the directory to include this provider: _____

Change Languages Spoken by provider: Please use this section to make any language corrections necessary for the directory

☐ Add:	☐ Delete:

Change Provider Name: Please use this section to make any spelling corrections necessary for the directory

Current Spelling:	Correct Spelling:

Member Notification: Per DHCS, members must be notified in writing of any significant changes in the availability or location of covered services, or any significant change in information.

Were members notified of the change(s) represented on this form?

☐ **Yes -** Please attach a copy of the notification ☐ **No**

How were members notified? Choose one

☐ Mailed Letters to members ☐ Posted Notice on the front window/in the lobby

Explanation of Changes listed above:

Information Verification

I hereby affirm that the information submitted in this application is correct and complete to the best of my knowledge and belief, and is furnished in good faith.

☐ **Please process the changes listed above with the effective date of __ / __ / __**

Printed Name of Person Completing Form: _____ Date: _____

Signature: _____ Title: _____

Contact Email: _____ Contact Phone:_____

Northern Region Counties (Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity) return this form to your Provider Relations Representative.

Southern Region Counties (Lake, Marin, Mendocino, Napa, Solano, Sonoma, and Yolo) return this by fax to 707-639-5503